Exhibit A

AFFIDAVIT OF STANLEY KIRK

Affiant, STANLEY KIRK, being first duly sworn, states as follows:

1. I have personal knowledge of the facts stated in this Affidavit and, if called as a witness, I would be competent to testify as to those facts.

2. I am general counsel for The Wellness Plan ("TWP"), have provided legal counsel to it from its inception, and as such, am intimately familiar with its operations, their legal implications, and their market context.

3. TWP is organized as a not-for-profit corporation, with its principal mission being to provide high quality medical care for people of limited means who might otherwise have difficulty obtaining affordable medical care.

4. The majority of persons receiving professional services from TWP are Medicaid recipients.

5. Funding for Medicaid services is, and for almost a decade has been, uncertain in quantity, making the funding of the sort of services TWP provides precarious.

6. There are a large number of indigent persons in need of medical services in and near the City of Detroit, and available medical services for such persons do not provide a comfortable margin for meeting their needs.

7. There are reports that other providers besides TWP who service this clientele are in uncertain financial condition due to the same sorts of funding issues that affect TWP, and more than one such major provider has recently had its continued ability to provide a full range of services to indigent persons in Detroit called into question.

8. If TWP were to cease to provide its services, there would be a serious and negative effect on the delivery of medical services to indigent persons in Detroit.

9. Before being placed into Rehabilitation, TWP was a mixed model HMO, providing services to members partly through staff professionals and partly through a network of contracting providers.

10. When TWP members used network providers for medical services, the providers generally did not bill TWP members directly, except for co-pays, with payment for these services being made by TWP directly to the providers.

11. If TWP fails to pay the providers, the providers, except in the case of commercial members using out-of-network services, are nevertheless barred from seeking payment for the services, except for the co-pay, from TWP members.

12. The net worth of TWP was stated, in the year-end financial statement for 2004, as $38,324,000.00.

13. There are currently over fifty medical malpractice claims or potential claims pending against TWP or its physicians and other health professionals whom TWP is obligated to indemnify.

14. Most of these malpractice claims involve birth defects, and the amount of compensatory damages being sought in a number of these claims exceeds one million dollars per claim.

15. The amount of money in the TWP Trust Fund for payment of medical malpractice claims, as of February 28, 2005, was $10,474,460.87.

16. It is uncertain whether excess insurance will be available to contribute toward the payment of these claims.

Further, affiant sayeth not.

Stanley R Kirk
STANLEY KIRK

Subscribed to and sworn before me this 17th day of May, 2005.

Polly J. Jones
Notary Public
My Commission Expires 8-17-07

POLLY J. JONES
NOTARY PUBLIC WAYNE CO., MI
MY COMMISSION EXPIRES Aug 17, 2007

Exhibit C

(b) To the guaranty association for the costs and expenses of administration with respect to the payment of claims.

(c) To claims of Michigan policyholders of the insurer and to claimants of those Michigan policyholders.

(d) To Michigan beneficiaries of insurance contracts owned by non-Michigan residents.

(e) To other Michigan claimants of the insurer.

(f) To claims of non-Michigan policyholders of the insurer and to claimants of those non-Michigan policyholders.

(g) To non-Michigan beneficiaries of insurance contracts owned by non-Michigan residents.

(h) To the stockholders or owners of the insurer.

(2) Upon request of a guaranty association of this state to which the insurer is a member, special deposits made by the insurer shall be transferred to that guaranty association for the payment of claims pursuant to this section.

P.A.1956, No. 218, § 8141a, added by P.A.1989, No. 302, § 1, Imd. Eff. Jan. 3, 1990. Amended by P.A.1994, No. 443, § 1.

Historical and Statutory Notes

The 1994 amendment, in subsec. (1)(c), inserted "Michigan", and substituted "those Michigan" for "such"; inserted subsec. (1)(d); redesignated former subsec. (1)(d) as subsec. (1)(e); in subsec. (1)(e), inserted "Michigan"; inserted subsecs. (1)(f) and (1)(g); redesignated former subsec. (1)(e) as subsec. (1)(h); and, in subsec. (1)(h), substituted "owners" for "members".

P.A.1994, No. 443, § 2, provides:

"Section 8141a of Act No. 218 of the Public Acts of 1956, being section 500.8141a of the Michigan Compiled Laws, as amended by this amendatory act is curative, reflects the original intent of the legislature, is retroactive, and is effective beginning January 3, 1990."

P.A.1994, No. 443, was ordered to take immediate effect, and was approved January 7, 1995 and filed January 10, 1995.

Prior Laws:

P.A.1943, No. 158, § 7.
C.L.1948, §§ 500.7848, 550.207.
P.A.1956, No. 218, § 7848.
C.L.1970, § 500.7848.
C.L.1979, § 500.7848.

Cross References

Loans and investments, calculation of amount for contingencies, see § 500.901.

Library References

Insurance ⇐1414
Westlaw Topic No. 217
C.J.S. Insurance §§ 164, 166

500.8142. Priority of distribution of claims; classes

Sec. 8142. (1) Except as provided in subsection (2), the priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section. Every claim in each class shall be paid in full or adequate funds retained for their payment before the members of the next class receive payment. Subclasses shall not be established within a class. The order of distribution of claims is as follows:

(a) Class 1. The costs and expenses of administration, including, but not limited to, the following:

(*i*) The actual and necessary costs of preserving or recovering the insurer's assets.

(*ii*) Compensation for all services rendered in the liquidation.

(*iii*) Any necessary filing fees.

(*iv*) The fees and mileage payable to witnesses.

(*v*) Reasonable attorney's fees.

(*vi*) The reasonable expenses of a guaranty association or foreign guaranty association in handling claims.

(*vii*) Debts due to employees for services performed to the extent that they do not exceed $1,000.00 and represent payment for services performed within 1 year before the filing of the petition for liquidation, if the court determines that the payments are reasonably necessary to an orderly and effective administration for the protection of class 2 claimants. Officers and directors are not entitled to the benefit of this priority. This priority is in lieu of any other similar priority authorized by law as to wages or compensation of employees.

(*viii*) Beginning January 3, 1990, the actual and necessary fees of a supervisor appointed pursuant to section 8109 [1] if the liquidation was preceded by supervision pursuant to section 8109 and the fees were not paid at the date of liquidation.

(b) Class 2. Except as otherwise provided in this section, all claims under policies for losses incurred, including third party claims, and all claims of a guaranty association or foreign guaranty association. However, obligations of an insolvent insurer arising out of reinsurance contracts shall not be included in this class. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values, shall be treated as loss claims. For purposes of this section, life insurance and annuity policies include, but are not limited to, individual annuities, group annuities, guaranteed investment contracts, and funding agreement contracts, issued by an insurer. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligation of support or by way of succession at death or as proceeds of life insurance, or as gratuities. A payment by an employer to his or her employee shall not be treated as a gratuity.

(c) Class 3. Claims of the federal government.

(d) Class 4. All claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property that are not under policies and, to the extent not included in class 1, debts due to employees for services performed to the extent that they do not exceed $1,000.00 and represent payment for services performed within 1 year before the filing of the petition for liquidation. Officers and directors are not entitled to the benefit of the priority for debts due to employees for services performed. The priority for debts due

to employees for services performed is in lieu of any other similar priority authorized by law as to wages or compensation of employees.

(e) Class 5. Claims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors.

(f) Class 6. Claims of any state or local government. Claims, including those of any governmental body for a penalty or forfeiture, are allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs incurred. The remainder of the claims shall be postponed to the class of claims under subdivision (i).

(g) Class 7. Claims filed late or any other claims other than claims under subdivisions (h) and (i).

(h) Class 8. Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies are limited in accordance with law.

(i) Class 9. The claims of shareholders or other owners. In paying claims pursuant to this class, disinterested shareholders have priority over interested shareholders who are directors or officers who fail to exercise their duties in accordance with section 5240. [2]

(2) If it is provided by written agreement, statute, or rule that the assets in a separate account are not chargeable with liabilities arising out of any other business of the insurer, that part of a claim that includes a separate account shall be satisfied out of the assets in the separate account equal to the reserves maintained in the separate account under the separate account agreement. The remainder of the claim shall be treated as a Class 2 claim against the insurer's estate to the extent that reserves have been established in the insurer's general account pursuant to statute, rule, or the separate account agreement.

(3) As used in this section:

(a) "Separate account" means a separate account authorized under section 925 [3] and established in accordance with the terms of a written agreement or a contract on a variable basis.

(b) "Insurer's estate" means all of the assets of the insurer less any assets held in separate accounts. The following assets shall not be considered separate account assets:

(*i*) Assets that represent money provided by the insurer initially to fund the separate account.

(*ii*) Assets that represent policy reserves that are properly allocable to the general account.

(*iii*) General account investments held in the separate account.

P.A.1956, No. 218, § 8142, added by P.A.1989, No. 302, § 1, Imd. Eff. Jan. 3, 1990. Amended by P.A.1991, No. 79, § 1, Imd. Eff. July 18, 1991; P.A.1996, No. 429, § 1, Imd. Eff. Nov. 26, 1996; P.A.1998, No. 279, Imd. Eff. July 27, 1998; P.A.2002, No. 359, Imd. Eff. May 23, 2002.

[1] M.C.L.A. § 500.8109.

Exhibit

D

State of Michigan
John Engler, Governor

Department of Consumer & Industry Services
Kathleen M. Wilbur, Director

Office of Financial and Insurance Services
Frank M. Fitzgerald, Commissioner

Division of Insurance
P.O. Box 30220
Lansing, Michigan 48909-7720
Toll Free (877) 999-6442
Lansing Area (517) 373-0220
Web site: www.cis.state.mi.us/ins

BILL ANALYSIS

BILL NUMBER:	**Senate Bill 1209 (Enrolled)**
TOPIC:	HMO Regulatory Reform
SPONSOR:	Senator Hammerstrom
COMMITTEE:	Health Policy
Analysis Done:	June 22, 2000

POSITION

The Office of Financial and Insurance Services supports this proposed legislation.

PROBLEM/BACKGROUND

A dual system of regulation currently exists between different forms of health care providers. Health maintenance organizations (HMOs) are regulated by the Department of Community Health and by the Office of Financial and Insurance Services. All other health care plans and health insurers are regulated by the Office of Financial and Insurance Services. As a result of the dual system of regulation, HMOs are not treated the same as other health care plans that offer essentially the same services and assume similar risks. It would be in the best interest of all consumers if all health care plans were regulated in the same manner and all had to meet the same requirements to create consistency in the health care market.

Current financial requirements for licensing HMO do not provide adequate protections for the consumers who rely on them for payment of health care services. Many smaller HMOs do not have enough working capital to maintain their business should they experience a major set back in their financial status from claims or investment income. The current system of licensing the HMOs allows them to become licensed with very little capital or net worth, putting them in a precarious position from the very beginning. If an HMO goes out of business, its enrollees are left trying to find new plans that will cover them, as well as having to find providers that contract with the new HMO. Finding adequate health care can be difficult for many consumers, but especially for those who already have health problems.

Regulation of HMOs in all financial aspects has become a more serious concern for all agencies that want to secure a stable health care system for Michigan's consumers. HMOs have become a

major force in the health care market, providing health services for more and more people every day. As their numbers grow, more importance must be placed on all financial aspects of that growth in order to guarantee their continued viability in the health care system and to provide more protections for consumers who need their services.

Current law does not allow the Commissioner to use enforcement action other than to take action against the HMO's license. If the HMO violates a specific provision of its law, the Commissioner cannot legally enforce any action other than by taking their license away. When faced with this choice, the Commissioner often finds removal of the HMO's license is not in the best interest of the state or the enrollees who rely on the HMO for their health care services. This situation can create difficulties for the enforcement agencies when they want the HMO to take a certain action that may benefit the consumer.

An HMO's request for a rate change can only be approved or disapproved. If the rate change request is disapproved because the rate appears to be inadequate for expected losses, then that leaves the HMO with an even more inadequate rate until a new filing can be submitted and reviewed for approval. This situation can leave the HMO in danger of becoming insolvent, if the requested rate change cannot be corrected quickly.

When an HMO becomes insolvent under the current law, enrollees are left to find their own replacement plan. No provisions exist to help them find alternative coverage or to transfer them to another plan. This problem along with the inadequate financial backing, can cause consumers to be in a vulnerable position at a time when they may be in great need of health care services. Without proper provisions for HMO insolvencies, the public cannot be guaranteed a stable health care environment.

DESCRIPTION OF BILL

This proposed legislation places regulatory oversight within the Insurance Code and subject to the oversight of the Commissioner of the Office of Financial and Insurance Services. It sets up procedures for the internal grievance procedures for health maintenance organizations. It provides for the enrollee's right to an independent review conducted by an independent review organization after October 1, 2000. It shortens the time line for resolution of formal internal grievances from 90 days to 35. The 35 day time period may be tolled for any period of time the insured or enrollee is permitted to take under the grievance procedure. The insurer or HMO can toll the number of days for up to 10 days if they have not received the requested information from the health care provider. An enrollee may authorize any person to act on his or her behalf. The proposed legislation essentially provides that HMOs must follow the standards found in Chapter 22 as insurers have in the past, when it involves grievance procedures. Insurers and HMOs must annually provide to the Commissioner a summary data report of grievances filed. It provides for revised financial standards and filing fees for licensing and revised solvency requirements for HMOs.

Chapter 35 is proposed as a new chapter in the Insurance Code to regulateHMOs. Many of the provisions have been directly transferred from the Public Health Code, others have received some modification and some are new. The proposed legislation transfers responsibility for

regulation of HMOs to the Division of Insurance from the Department of Community Health. Definitions are provided at the beginning of the chapter to define critical terms used in the regulations.

Section 3503 This section adds HMOs to those entities subject to regulations found in Section 223, Chapters 34 and 36, with specific exceptions from Sections 408, 410, 411, 901, and 5208 and Chapters 77 and 79 of the Insurance Code.

Section 3505 An HMO must receive a certificate of authority before issuing HMO contracts. An HMO licensed under former Part 210 of the Public Health Code automatically receives a certificate of authority under this chapter. The term "health maintenance organization" may not be used by entities other than those licensed under this act. HMOs may not use the words "insurance, casualty, surety, or mutual" or any other word descriptive of insurance in their names.

Section 3507 HMO's must provide an acceptable quality of care by qualified personnel, health care facilities, equipment, and personnel required to provide HMO services, operational arrangements that integrate the delivery of various services, and a financially sound prepayment plan for meeting health care costs.

Section 3508 An HMO must develop and maintain a quality assessment program to be filed with the Commissioner, establish and maintain a quality improvement program to be filed with the Commissioner, a written statement of the program's objectives, an annual effectiveness review of the program, and a written quality improvement plan with analysis and measurement of quality of care issues.

Section 3509 An application for a certificate of authority must be filed with the Commissioner listing a specific service area on the application. If the HMO seeks to change the service area, it must request approval of that change with the Commissioner.

Section 3511 By the end of the first 12 months of operation, an HMO governing body shall have a minimum of 1/3 of its membership consist of adult enrollees who are not compensated officers, employees, or stockholders who own more than 5% of the organizations shares, or other people with financial interest in the organization. This section sets up requirements for election of board members and requirements that the board meet quarterly.

Section 3513 This section gives the Commissioner authority to regulate the health delivery aspects of the HMO operations and encourages it to use a wide variety of health-related disciplines and facilities, as well as services for prevention of disease and disabilities. The Commissioner has the authority to regulate the financial business practices to assure that the organizations operate in the interest of the enrollee using cost containment measures and acceptable quality of care. Services must be provided 24 hours a day and 7 days a week for the treatment of emergency episodes of illness or injury. They must provide continuous evaluation of the quality of health care. Provisions must exist for the enrollee to obtain emergency health services both within and outside of the service area. The HMO must provide a reasonable

grievance process for enrollees. An HMO must be a distinct legal entity under the Business Corporation Act or the Michigan Limited Liability Company Act.

Section 3515 An HMO may provide additional health services not required by this act. It may have nominal copayments that do not exceed 50% of an HMO's reimbursement to an affiliated provider for providing the service to an enrollee and must not be based on the provider's standard charge for the service.

Section 3517 An HMO may not provide for payment of cash or other material benefit to an enrollee, except in certain circumstances. It may reimburse enrollees for treatment given for an out-of-area emergency service authorized by the HMO.

Section 3519 This section requires rates charged for the HMO's contracts to be fair, sound, and reasonable in relation to the services provided, and procedures for offering and terminating services shall not be unfairly discriminatory. Contracts and contract rates shall not be discriminatory based on race, color, creed, national origin, residence within an approved service area, lawful occupation, sex, handicap, or marital status, except marital status may be used for classification purposes. Rate differentials may be approved for sex, age, residence, disability, marital status, or lawful occupation if supported by sound actuarial principles, a reasonable classification system, and is related to actual and credible loss statistics or reasonably anticipated experience for a new coverage. An HMO contract must provide, at a minimum, basic health services.

Section 3521 The methodology used to determine prepayment rates and any change to that methodology or rate must be filed with Commissioner before becoming effective. Supporting data must be submitted to establish the financial soundness of the prepayment plan or rating methodology. The Commissioner may annually require a schedule of rates for all subscriber contracts and riders.

Section 3523 An HMO contract must be filed with and approved by the Commissioner. An HMO contract must include:

1. Name and address of the organization.
2. Definitions of terms subject to interpretation.
3. Effective date and duration of the coverage.
4. Conditions of eligibility.
5. A statement of responsibility for payments.
6. A description of benefits and services available within the service area, and copayments.
7. A description of emergency and out-of-area services.
8. A specific description of limitations, exclusions, and exceptions, including any preexisting condition limitations.
9. Confidentiality agreements, an enrollee's right to choose primary care physician or other provider, availability of service, and other rights to inspect medical records.
10. Covenants of the subscriber must address timely payments, nonassignment of benefits, truth in application and statements, notification of change in address, theft of membership identification.

11. A statement of responsibility and rights regarding the grievance procedure.
12. A statement regarding subrogation and coordination of benefits.
13. Conversion rights.
14. Provisions for adding new family members or other acquired dependents.
15. Provisions for grace periods for late payments.
16. Terms under which the HMO or the subscriber can terminate the contract.
17. A statement of the nonassignability of the contract.

Section 3525 If the HMO wants to change a contract or a rate charged, the request must be filed with the Commissioner and shall not take effect for 60 days after the filing, unless the Commissioner approves otherwise. The Commissioner has 60 days after the date of filing to approve, disapprove, or approve with modifications. The HMO may request a hearing to be held within 30 days of the request. Within 30 days after the hearing, the Commissioner shall notify the organization in writing of the disposition of the revised contract or rate. If the revised contract is the result of collective bargaining, this section does not apply, but the contract and rate must be filed with the Commissioner. Enrollees must be notified of any changes 30 days before the effective date of the change.

Section 3527 An HMO shall not terminate a contract or deny renewal based on age, sex, health status, national origin, or frequency of utilization of medically indicated services for the enrollees. A contract may be terminated for violation of the terms of the contract or for nonpayment if not paid within 30 days after the due date.

Section 3528 An HMO must do all of the following:

1. Establish written policies for credentialing verification of health care professionals.
2. Verify credentials of health care professionals before contracting with them.
3. Establish a credentialing verification committee.
4. Make available for review by health care professionals credentialing requirements.
5. Retain all credentialing records of health care professionals for at least 2 years.
6. Keep credentialing information confidential, except as required by law.

An HMO must obtain verification of the following information about a provider applicant:

1. Current license to practice medicine in this state and history of license.
2. Level of professional liability coverage.
3. Status of hospital privileges.
4. Specialty board certification status.
5. Current drug enforcement agency registration certificate.
6. Graduation from medical school.
7. Completion of postgraduate training.

An HMO must have the following information for an affiliated provider:

1. Current license history in this state and other states.
2. The health professional's malpractice history.

3. The health professional's practice history.

An HMO must obtain at least every 3 years verification of all of the following for a participating health professional:

1. Current license to practice medicine in this state.
2. Current level of professional liability coverage.
3. Status of hospital privileges.
4. Current DEA registration certificate.
5. Specialty board certification status.

HMOs must require providers to advise them of any changes in status of any of the listed items. A health care professional must be provided the opportunity to review and correct information concerning credentialing. An HMO must notify the health professional of any information obtained that does not meet the credentialing verification standards. The health care professional has the right to correct any erroneous information. HMOs are responsible for all credentialing activities whether they do the actual credentialing or not. They may use other credentialing requirements than those listed.

Section 3529 HMOs may not discriminate against a health care professional based on the class of the health profession to which they belong. HMOs must enter into contracts with providers. An affiliated provider contract must prohibit the provider from seeking payment from the enrollee for services provided pursuant to the contract, except for copayments. An affiliated provider contract must contain all of the following:

1. Assuring the provider meets applicable licensure or certification requirements.
2. Access by the HMO to records or reports concerning services to enrollees.
3. The provider must cooperate with the HMO's quality assurance activities.

The Commissioner may waive contract requirements if the HMO is unable to obtain a contract and accessibility to patient care would not be compromised. An HMO must maintain a hospital reserve fund equal to 3 months projected claims, when 10% or more of the elective inpatient admissions occur in hospitals with which they do not have a contract. The HMO must submit to the Commissioner for approval standard contract formats proposed for use with its affiliated providers or any substantive changes to those contracts. The HMO must demonstrate that it has sufficient number of contracts with a sufficient number of providers to enable it to deliver the services it proposes to offer.

Section 3530 An HMO must maintain contracts with numbers and types of providers that are sufficient to assure that services are available without unreasonable delay. The Commissioner can review these services. If the HMO has an insufficient number of providers, they must ensure the enrollee can obtain the covered benefit at no greater cost to them than if they obtained the service from their providers. The HMO must maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of enrollees.

Section 3531 This section applies if the HMO contracts for affiliated providers or offers a prudent purchaser contract. The HMO may limit the number of contracts if the number of contracts is sufficient to assure reasonable levels of access to services for enrollees. An HMO must give all health care providers that provide the applicable health maintenance services and are located in the service area an opportunity to apply to become an affiliated provider. A contract must be based on the following written standards, which are to be filed with the Commissioner:

1. Standards for maintaining quality health care.
2. Standards for controlling health care costs.
3. Standards for assuring appropriate utilization of health care services.
4. Standards for assuring reasonable levels of access to services.
5. Other standards considered appropriate by the HMO.

An HMO must develop and institute procedures to notify health care providers of the acceptance of applications for a provider panel. The notice must be given at least 30 days before the initial provider application period. It must have an initial 60 day application period. It must have a 60 day application period at least once every 4 years. Notice of the application period must be given 30 days in advance. Within 90 days after the close of the application period, or within 30 days following the completion of the physician credentialing process, the HMO must notify the applicant whether they were accepted or rejected. If rejected, it must indicate why. If the contract with an affiliated provider is terminated, the affiliated provider must be told why, if it is requested. An HMO that is providing prudent purchaser services to an insurer must provide the insurer with information requested by the insurer that the organization has and that the insurer needs to comply with Section 2212.

Section 3533 An HMO may offer prudent purchaser contracts in conjunction with those contracts an HMO may pay or reimburse enrollees for unauthorized services or for services by nonaffiliated providers in accordance with the terms of the contract. Prudent purchaser contracts and the rates charged for them are subject to the same regulatory requirements as health maintenance contracts. The rates must not have an anticompetitive effect or result in predatory pricing in relation to prudent purchaser agreement coverages offered by other organizations. An HMO cannot issue prudent purchaser contracts unless it meets statutory financial requirements. Financial records for prudent purchaser contracts must be maintained separately from the financial records of other operations carried out by the organization.

Section 3535 Advertising for HMO services must not include information about the providers used by the HMO, nor shall it offer material benefit or items of value as inducement to prospective subscribers.

Section 3537 After an initial 24 months of operation, an HMO must have an open enrollment period of not less than 30 days at least once each consecutive 12-month period. During the enrollment period, it must accept up to its capacity individuals in the order in which they apply. The HMO cannot unfairly discriminate based on age, sex, race, health, or economic status of the applicant. The Commissioner may waive this requirement if:

1. It has enrolled, or will be compelled to enroll, a disproportionate number of individuals who are likely to utilize its services more often than the actuarially determined average and enrollment of those individuals will jeopardize its economic viability.

2. If it maintained an open enrollment period, it would not be able to comply with the rules promulgated under this chapter.

An HMO which provides services to specified groups may accept members of those groups before accepting other individuals in the order of which they apply. An HMO may rate individuals who are not members of a group on the basis of actual and credible loss experience.

Section 3539 An HMO may have a preexisting condition exclusion of six months for an individual covered under a nongroup contract or a contract not covered under subsection (2). It may not limit or exclude preexisting conditions for an individual covered under a group contract. Nongroup contracts must be renewed at the option of the individual except in cases of fraud, intentional misrepresentation of material fact, lack of payment, if the HMO no longer offers that type of coverage, or if the individual or group moves outside the service area. A group contract shall be renewed at the option of the sponsor of the plan, except for the above mentioned conditions. Group means a group of two or more subscribers.

Section 3541 An HMO can not prohibit a health professional from advocating on behalf of an enrollee for appropriate medical treatment options pursuant to the procedure in Section 2213 or the Patients' Right to Independent Review Act or from discussing with an enrollee or provider health care treatments and services, quality assurance plans, the financial relationship between the HMO and the health professional, whether a fee-for-service relationship exists, whether a capitation arrangement exists, or whether payments to providers are made based on standards relating to cost, quality, or patient satisfaction.

Section 3542 An HMO may not use a financial incentive as an inducement to deny, reduce, limit or delay medically necessary and appropriate services. This section does not prohibit payment arrangements not tied to specific medical decisions or prohibit the use of risk sharing.

Section 3543 With the Commissioner's approval, an HMO may invest in a Third Party Administrator (TPA) under the following conditions:

1. The TPA is a distinct legal entity.
2. The TPA has a certificate of authority.
3. The TPA is financially sound and maintains adequate working capital.
4. The investment does not endanger the continued operation of the HMO.
5. The TPA maintains separate financial records.

A TPA invested in by the HMO is still subject to all the requirements under the TPA Act. An individual covered under a plan administered by a TPA is not liable for incurred medical expenses for covered services if the plan continues to pay the medical expenses that are eligible for payment.

Section 3545 With approval of the Commissioner, an HMO may acquire obligations from another managed care entity.

Section 3547 The Commissioner may visit or examine the health care service operations of an HMO and consult with enrollees at any time. The Commissioner has access to all information of the HMO relating to the delivery of health services. The Commissioner may require the submission of information regarding a proposed contract between an HMO and affiliated provider.

Section 3548 An HMO must keep all of its books and financial papers at or under the control of its principal place of doing business in this state. The records must be kept separate from any other operation carried on by the person licensed under this chapter to operate an HMO. An HMO must hold and maintain legal title to all assets and they must not be commingled with affiliates or other entities, even in a holding company system.

Section 3549 An HMO must notify the appropriate board of any disciplinary action for any of the Public Health Code requirements that results in a change of employment status of a physician or dentist under contract to the HMO. The notice must be sent in writing to the appropriate board within 30 days after the change occurs.

Section 3551 An HMO's net minimum net worth shall be determined using accounting procedures approved by the Commissioner that ensure that the organization is financially and actuarially sound. An HMO that was licensed through the Public Health Code on the effective date of this act shall possess and maintain unimpaired net worth as required under former Section 21034 of the Public Health Code until the earlier of the following: the HMO attains a level of net worth as provided in subsection (3), or December 31, 2003.

An HMO applying for a certificate of authority after implementation of this act or one wishing to maintain its certificate of authority after December 31, 2003 must comply with Section 403, but not less than the following:

1. For an HMO that contracts or employs providers in numbers sufficient to provide 90% of the HMO's Benefit payout, minimum net worth is the greatest of one of the following: $1,500,000, or 4% of the HMO's subscription revenue, or 3 months uncovered expenditures.

2. For an HMO that does not contract in sufficient numbers to provide 90% of the HMO's benefit payout, minimum net worth is the greatest of the following: $3,000,000, or 10% of the HMO's subscription revenue, or 3 months uncovered expenditures.

The Commissioner shall take into account the risk-based capital requirements as developed by the National Association of Insurance Commissioners (NAIC) in order to determine adequate compliance with Section 403.

Section 3553 Minimum deposit requirements for an HMO shall be determined and it must use accounting procedures approved by the Commissioner. An HMO licensed under former Part 210 of the Public Health Code on the effective date of this chapter that automatically received a

certificate of authority must possess and maintain a deposit as required under former Section 21034 of the Public Health Code until the earlier of the following: The HMO attains the level of deposit as provided in subsection (3) and continues to maintain that level, or December 31, 2001.

An HMO applying for a certificate of authority on or after the effective date of this chapter or an HMO wishing to maintain a certificate after December 31, 2001 must have a deposit in an amount determined by the Commissioner but not less than $100,000.00 plus 5% of annual subscription revenue up to a $1,000,000.00 maximum amount.

Section 3555 An HMO must maintain a plan evaluating cash flow needs and adequate working capital that does all of the following:

1. Demonstrates compliance with all HMO financial requirements of this chapter.
2. Provide for adequate working capital, which shall not be negative at any time.
3. Identify the means of achieving and maintaining a positive cash flow.

Section 3557 An HMO must file notice with the Commissioner of any substantive changes in operation no later than 30 days after the change. A substantive change includes a change in the HMO's officers or directors, a change in the location of corporate offices, a change in the organization' articles of incorporation or bylaws, a change in contractual arrangements under which the HMO is managed, or any other significant change in operations.

Section 3559 An HMO must obtain a reinsurance contract or establish a plan of self-insurance to ensure solvency or to protect subscribers in the event of insolvency. The reinsurance contract must be filed for approval with the Commissioner not later than 30 days after the finalization of the contract. A reinsurance contract or plan shall be considered approved 30 days after it is filed with the Commissioner unless disapproved in writing before the end of the 30 days. An HMO must maintain insurance coverage that includes fire, theft, fidelity, general liability, errors and omissions, director's and officers liability coverage, and malpractice insurance. The Commissioner must approve a plan to self-insure.

Section 3561 An HMO must have a plan for insolvency that allows for continuation of benefits for the duration of the contract which has been paid for and continuation of benefits to any member confined on the date of insolvency in an inpatient facility until discharged from that facility. The plan is satisfactory if the HMO has:

1. A financial guarantee contract insured by a surety bond issued by an independent insurer with a secure rating.
2. A reinsurance contract issued by an authorized or eligible insurer to cover the expenses to be paid for continued benefits after insolvency.
3. A contract between the HMO and its affiliated providers that provides for the continuation of services in the event of insolvency.
4. An irrevocable letter of credit.
5. An insolvency reserve account established with a federal or state chartered financial institution under a trust indenture, equal to 3 months premium income.

Section 3563 If an HMO becomes insolvent; the Commissioner may order all other HMOs and health insurers that participated in the enrollment process with them at a group's last regular enrollment period to offer the group's enrollees a 30-day enrollment period. Each of those HMOs or health insurers must offer the enrollees the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period. If no other HMO or health insurer had been offered to the group, or if the Commissioner determines no other HMO or health insurer has sufficient health care delivery resources to take this business, then the Commissioner will allocate equitably the insolvent HMO's group contracts among all HMOs that operate within a portion of the service area. Each HMO that takes a share of the business must offer the group their coverage that is most similar to the previous group coverage with the insolvent HMO at rates using their current rating methodology. The Commissioner may allocate nongroup enrollees in the same manner, except the new HMO or health carrier will not use a preexisting condition limitation for those enrollees.

Section 3565 A nongroup subscriber may cancel an HMO contract within 72 hours after signing. Any deposit or prepayment will be refunded within 30 days of receipt of the notice of cancellation. The subscriber will be responsible for payment of any fees for services provided during those 72 hours. The cancellation notice must be in writing to the organization or its agent. Notice of cancellation will be sufficient if it indicates the intent of the person not to be bound by the contract. The right of cancellation must appear in boldfaced type on the same page the individual subscriber signs to bind the contract.

Section 3567 An HMO contract must clearly delineate all conditions under which the HMO may cancel coverage for an enrollee. A contract for nongroup subscribers must specify an enrollee's rights and options in the case of a proposed amendment or change in the contract or the rate charged. Continued prepayment by the subscriber during the period of appeal does not constitute acceptance of the change in the contract or the rate.

Section 3569 An HMO can assume full financial risk on a prospective basis for the provision of health services. However, it may do any of the following:

1. Require an affiliated provider to assume financial risk.
2. Obtain insurance.
3. Make other arrangements for the cost of providing to an enrollee services the aggregate value of which is more that $5,000 in a year for that enrollee.

If the HMO requires an affiliated provider to assume financial risk under the terms of its contract, the contract must require the following:

1. The HMO to pay the provider directly or through a TPA for services provided to its enrollees.
2. The HMO must keep all pooled funds and withhold amounts and account for them on its financial books and reconcile them at year end in accordance with the written agreement.

Section 3571 An HMO can meet the requirements of and accept money from, and enroll beneficiaries or recipients of state and federal health programs.

Section 3573 A person wanting to operate a system of health care delivery and financing in exchange for a fixed payment and organized so that providers and the organization are some part at risk for the cost of services, but fails to meet the requirements set forth in this chapter, may operate such a system if the Commissioner approves. The operation will be authorized and regulated in the same manner as an HMO, except to the extent that the Commissioner finds that the regulation is inappropriate. However, such a system shall not advertise or solicit itself in any way as an HMO authorized under this chapter.

SUMMARY OF ARGUMENTS

Pro

Placing the regulation of the HMOs under the Office of Financial and Insurance Services removes the dual system of regulation over managed care organizations. Personnel at the Division of Insurance have years of experience regulating health care providers. This proposed legislation puts regulation of all health care providers under one authority in order to provide continuity and similarity in that regulation. All health care providers will be subject to similar duties and expectations.

The proposed legislation would increase the net worth, statutory deposit, and working capital requirements for HMOs. As a result of these changes, HMOs should become more financially viable and more able to meet the future needs of a rapidly growing health care industry. One of the concerns of regulators is to provide a stable insurance and health care service environment for consumers. Once HMOs meet the new financial requirements, they should be in a better position to meet current demands on their reserves, as well as strategically gear them towards growth in meeting the demands of the future.

The proposed legislation changes the reporting and examination requirements of HMOs to make their regulation more in line with the requirements for health insurance companies. The Commissioner will have more control over the time frame in which annual statements must be filed and in the form they must be filed. The new examination provisions allow the Commissioner greater access to an HMO's records. These enhanced reporting requirements will benefit both subscribers and providers, since the state regulating agency will be able to develop a clear picture on a regular basis of the financial operations of the HMO.

The proposal eliminates the requirement that HMOs be relicensed every three years. As with insurance companies, they can now receive a permanent certificate of authority that can only be removed if they become insolvent or fail to comply with the requirements of the statute. They will pay the same application fees as insurers and the same assessment percentage as insurers to help support the increased regulatory duties of the Division of Insurance. The increase in their assessment will be off set by the elimination of the licensure and relicensure fees the HMOs currently pay the Department of Community Health.

The proposal changes the requirements for holding of assets, notification to the Commissioner of any changes in the officers, directors, or investors of the HMO to be approved by the Commissioner, and they would be subject to the same disclosure of affiliated relationships and transactions with affiliates as insurers. The Commissioner must always receive prior notice of these types of transactions in order that the subscribers' interests will be protected and that no conflict of interest occurs when the HMO's officers and directors are involved in a transaction. The increased ability to monitor these activities will enhance the financial solvency of the HMOs and provide greater stability for the subscribers.

The new legislation gives the Commissioner another enforcement tool against the HMOs other than taking action against their license to do business in Michigan. Often removing the company's license is not the most effective or efficient way to protect Michigan consumers. Under this legislation, HMOs will be subject to the Commissioner's cease and desist authority as well as to civil fines. These provisions will give the Commissioner a progressive system of discipline for companies that continually violate the statute.

The legislation allows the Commissioner to approve a rate change filing with modifications that will allow HMOs to continue operating using rates that the Commissioner deems appropriate for their risk assumption. If a rate increase request was disapproved because the rates were found to be still inadequate, then the HMO could be in danger of insolvency because they would have to continue using the old rate structure that both parties agree were very inadequate until a new filing could be presented and approved.

The new legislation gives the Commissioner greater control over risk sharing between the HMO and the providers. These situations can be more closely monitored to assure financial stability. The Commissioner also has greater control over expansion of the HMO into new service areas. He has the ability to determine if the HMO has the capital to sustain additional underwriting losses in a service area until their business grows adequately.

The proposal gives the Commissioner authority in the event of insolvency to order other carriers who may be covering an affected group to offer a 30-day open enrollment period to the subscribers of the insolvent HMO. If there are not other carriers involved with the affected groups or individuals, the Commissioner may also allocate enrollees to other HMOs in a service area. This action will aid consumers when their health carrier can no longer provide the needed services. They will not be forced to seek other coverage on their own unless they choose to do so. The order by the Commissioner can make the transition from health carrier to another much easier for the subscriber.

Con

The new financial regulations may cause some difficulties for currently licensed HMOs. If they are not able to meet the net worth requirements by December 31, 2003, they will have to cease doing business in Michigan. The previously licensed HMOs must also be able to meet the new requirements for levels of deposit by December 31, 2001 or lose their license. Although these requirements are meant to ensure continued operation of HMOs for the subscriber's protection, if these HMOs cannot meet the new requirements on time, their subscribers will be forced to seek

health services with another carrier. This situation may cause some temporary frustration and difficulties for the consumer at that time.

FISCAL INFORMATION

The new responsibilities to be assumed by the Division of Insurance will cause the need for personnel to perform these duties. The revised assessment amounts and the licensure fees should help mitigate those costs.

ECONOMIC IMPACT

The economic impact of these changes on the health care industry should be a positive one. HMOs will be subject to the same regulation as health insurance companies have been. The new financial and reporting requirements will help the regulators quickly identify troubled companies or companies that may be headed in that direction. A quicker resolution to their problems will more efficiently protect consumers and keep the health care market healthy and competitive, which always works to the consumer's advantage.

ADMINISTRATIVE RULES IMPACT

The promulgation authority granted under Part 210 of the Public Health Code would be eliminated.

Frank M. Fitzgerald
Commissioner

June 22, 2000
Date